FEB. '50

FEBRUARY • 1950

the CHILD

FOSTER HOMES IN MEDICAL-CARE PROGRAMS FOR CHILDREN

ELIZABETH E. BISSELL, *General Secretary, the Children's Mission to Children, Boston*

FOSTER care for children has many reasons for being, many uses. One specialty is the placement of children away from their own homes in medical foster care. The Children's Mission to Children, a century-old privately supported agency in Boston, provides this care for children with medical problems. It is the only agency giving this service in this locality, because of a joint decision made by the children's agencies of Boston.

The work of the Children's Mission to Children has gone through many changes during the agency's recently completed hundred years, but it has always held to the original aim of "helping any child in need of a friend." (In its most recent change, early in 1949, the agency affiliated with the Children's Medical Center and moved its office so as to be near the center.) The agency has been placing children in foster care for five decades and placing them in medical foster care for three of these decades.

The agency now serves hospitals, clinics, private practitioners, and social agencies by providing foster-home care for convalescent children who, for medical reasons, should not go home for a while. It also places in foster care children who have been ill in their own homes, but for full recovery need convalescent care elsewhere.

In these carefully chosen foster homes the children accepted by the agency for care make the transition back to their ordinary mode of life.

Naturally, many problems arise when an active child's life is suddenly changed to one in which he must curb his energy, giving up almost every activity he has. The problems may be physical difficulties, emotional disturbances, or the break in his education. Many of the children are recovering from rheumatic fever or chorea and so need long-time care and the service of several types of specialists if they are to make all-round progress as well as physical recovery. Physicians, nurses, social workers, foster parents, occupational therapists, school teachers, and others work together to bring about a new, unhindered start for children who have had serious set-backs.

Homes of two kinds

The Children's Mission to Children offers medical foster care to boys and girls in two types of homes:

Care in the homes called by the agency "medical homes" or "group bed homes." These homes serve children needing bed care, such as children with bronchiectasis, arthritis, nephritis, hemophilia, spinal fusion, asthma, cerebral palsy, or rheumatic fever.

From 4 to 14 children are cared for in a home. The agency would prefer to limit the number to 6 if that could be worked out. As it is, the foster mothers who care for a larger number than that are unusually competent women, able to maintain individual relations with each child in their constantly changing groups, and the conditions in their homes are unusually advantageous. The agency guarantees regular payment for a specified number of children in each home, regardless of whether all the beds are filled. It usually has about five such homes at one time.

Care in Eliot House, a convalescent home owned by the agency, is for about 12 boys at a time. It was opened in 1946 because of a shortage of family foster homes for medical care.

A child in one of these homes is considered ready to return to his own home or to be transferred to a "nonmedical home," which will be described here, only when he is able to be up and about for 8 hours in the course of a day.

A study made of the agency's program in 1947 showed the median length of care in medical homes to be from 3 to 4 months.

Care in the "nonmedical" or "up" homes for ambulatory children who have medical problems. The purpose of these homes is to give a natural family setting to children who can be out of bed but whose activities must be restricted, who must have rest periods, good food, and medical supervision.

Children whom we are most apt to place with an individual foster family are in one of two groups. They are children who, to safeguard their health, need long-time care away from home, or who need summer-vacation care in suburban or country homes to get them away from city slums or other unfavorable city conditions. The latter may be children who are past the convalescent stage of rheumatic fever but are not yet well enough to go to a regular summer camp.

About 20 nonmedical homes may be in use at one time. The median length of care in these "up" homes was, at the time of the study, from 2 to 3 months.

The boys and girls under care

The number of children under the care of the agency at any one time is approximately 80. Some of them are being served in some way in their own homes. The number is smallest in the autumn before rheumatic fever in the acute stage is prevalent. About 50 percent of the children cared for have had rheumatic fever. During the summer vacation from 20 to 30 children are added to the usual number—children who need help in keeping their activities limited and in following the preventive measures required of them.

Most of the referrals are made by

hospitals. When a request for service is received, the child's mother and father usually visit the agency's office to discuss the matter. If they decide they want the agency to give service, and placement is possible, the plan is talked over with the child before any arrangements are made. Parents and child take part in whatever planning is done.

The boys and girls accepted for admission are, in general, from 2 to 21 in age, without infectious disease, and not acutely or hopelessly ill, although the prognosis may be poor or questionable. There are no residence restrictions, and no restrictions based on race, religion, or finances. The family is expected to pay all or part of the child's expenses, if possible. But whether the family can pay is not considered in deciding about acceptance. "Can the service help this child? And have we a suitable vacancy for him?" In general, the answers to these questions decide the acceptance of an application.

It is hard for a child to stay quiet when he is getting well. An occupational therapist can help such children to keep busy and happy without their becoming too fatigued or excited.

The foster mother is the pivot

Any placement agency undertaking to care for children with problems arising from illness has, as the core of its responsibility, the job of restoring boys and girls to health as quickly as possible. It tries to do this by facilitating any medical treatment being carried on by the hospital, clinic, or private physician referring a child for foster-home care. The direct responsibility for the child's daily care rests with the foster mother. Therefore it is the agency's duty to select women in whom it can place full confidence. In this program foster mothers are chosen for the same personal qualities that are required for any foster care in family homes—the qualities that make a good mother. They are warm-hearted, yet calm under stress; they understand children. In addition, these foster mothers are chosen for their appreciation of how children react to illness and how different diseases affect children. (Many of our foster mothers are graduate nurses.) A foster mother must help a child who has been ill, and who is away from his family, to be contented with his surroundings and to follow the regimen planned for him by his doctor.

The agency should appreciate fully the significance and worth of the job a foster mother assumes and should compensate her adequately. Having financial security is important to a woman who undertakes in her home the care of a number of children who are confined to bed or of one child who is under special medical treatment.

The Children's Mission to Children pays its foster mothers for the care they give in group bed homes from $14 to $21 a week for each child. Providing equipment is the responsibility of the foster mother. But expenses she incurs for the children, such as medicines, haircuts, clothing, transportation, allowances, are chargeable to the agency.

Foster mothers make financial agreements with the agency's administrator —its general secretary—and the supervisor of foster care. The agreements usually run for a year, at the end of which time an evaluation of the foster care is made and adjustments may take place to improve the service. However, the agreements are not necessarily binding for a full year and may be changed at any time if it is desirable.

A child's mother and father need to feel confidence in the person who is to care for their ailing child. Some get this confidence from their belief that the agency will choose foster parents wisely, and they accept the choice without question. Others wish to see and judge the foster home for themselves during the planning period, before the child is placed. An opportunity for a visit is, of course, arranged. If they wish, the parents go with their child and the case worker on the day the boy or girl enters a foster home. The agency encourages the fathers and mothers to go if they seem hesitant about it.

Parents are urged to visit their children once a week. Visiting hours in group bed homes are arranged to coincide, at regular intervals, with the medical director's call, so that parents may talk with him about their son or daughter.

The medical director

The medical director of the agency is a specialist in rheumatic fever. He serves the agency part time in addition to carrying on his private practice and his staff work at two hospitals, the Children's Hospital and the House of the Good Samaritan. The latter gives sanitorial care to children who have rheumatic fever. Because many of the children come to the foster homes from these hospitals they have the advantage of continuity of medical care during the

acute and convalescent stages of their illness.

The medical director makes regular visits to group bed foster homes and in addition is on call to these homes at any time. He may be consulted on any case in the care of the agency. On three afternoons a week children may be taken to his office for examinations. He is consulted on the admission and treatment of every child with rheumatic fever, cardiac involvement, arthritis, or chorea. Two physicians who are his assistants make additional visits to the homes.

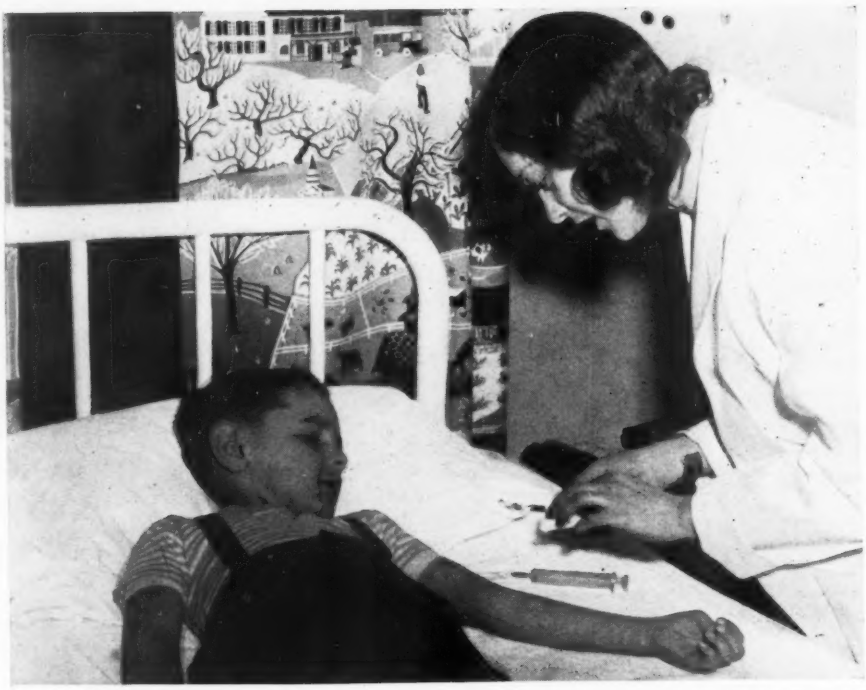
Children who have had illnesses other than rheumatic fever are supervised medically by the hospital, clinic, private practitioner, or medical agency that referred them. They are taken regularly to hospital, clinic, or doctor's office, according to the source of their supervision, for examination or treatment.

In the nonmedical foster homes, foster parents report any illnesses, however slight, to the agency. If a child who is being supervised medically by a clinic or hospital shows signs of illness, the supervising clinic or hospital is notified at once. A foster mother may call her own physician in an emergency, with the approval of the medical director, but in practice it is seldom necessary. Case workers, foster mothers, or case aides take children to clinics in the agency's car or in an ambulance for routine check-up examinations or for special treatment.

Others who visit the homes

The agency's laboratory technician visits the group bed homes regularly and also when called there for specific reasons.

Occupational therapy is given when a doctor prescribes it. An occupational therapist, who is a full-time staff member, visits the group bed homes twice a week. Her type of work is treatment through activity—either mental or physical activity. The doctor indicates the diagnosis, the results that he wants to achieve, and the precautions to be observed. With these instructions and information about the child and his family the therapist selects activities best suited to help bring about the physical and psychological results the doctor is trying to bring about.



This technician's report to the doctor will help him to judge the little patient's progress.

Treatment, which may be given to individuals or in groups, includes such arts and crafts as leatherwork, puppetry, sewing, woodwork, finger painting, and such recreation as singing and dramatics. The activities suitable for our rheumatic-fever patients (they constitute about 90 percent of the children in our two group bed homes) are those that are "freeing" and creative.

The agency's social case workers visit the homes whenever it is necessary—they have no regular schedules. Their coming depends on the needs of the individual children and on when the foster mothers want to talk over special matters. The agency places much emphasis on its case-work services. These services are discussed at length further on. (See *Social Case-work Service*, on next page.)

The Board of Education supplies teachers for the children, just as it does for other home-bound boys and girls. Various churches send volunteers to give religious instruction to the young people of their own denominations while they are in the homes.

The Visiting Nurse Association of Boston arranges for its public-health nurses to go to the foster homes whenever their services are needed.

To everyone, having satisfactory living surroundings means a great deal. To an ill child who is wholly or partially isolated from most of his usual contacts, his background is particularly important.

Living conditions

Houses selected for the care of small groups of convalescent children need to be spacious enough so that the children can use more than the space immediately around their beds. One advantage of foster care in a home is that the patients may take part in family life. A child convalescing from an acute attack of rheumatic fever, who has advanced from complete bed care to being allowed to get out of bed to go to the bathroom, can at least stop by the kitchen on his way back to bed to see what's cooking or to suggest something he would like to have for dinner.

What factors does a home finder on the agency's staff consider when she is studying a prospective home for group foster care? She considers the location of the house, its exposure to the sun, its ventilation, its heating facilities, and the location of its bathrooms. She considers whether its stairs are easy to use, whether it has rooms for isolating patients and space for teaching and for

occupational therapy; she notes the nearness of children's rooms to the center of household activities, the yard space suitable for outdoor recreation, and the nearness of the house or the convenience of transportation to the city's medical centers.

The standards outlined for group bed homes cover practical aspects. The agency's requirements specify the equipment necessary, such as beds, bedside facilities, linen, and thermometers. The requirements cover the diet, the preparation and serving of food, the changing of bed linen, house-cleaning methods, the care of patients, and the clothing to be supplied. Other subjects covered are: Safeguarding the children against infection; visiting days and hours; competent assistants for the faster mother; and her reports to the agency.

The foster mothers in a medical-care program find it helpful to meet to discuss their common experiences and problems and to hear speakers on subjects close to their work. Such meetings have been held quarterly, and the foster mothers have recently organized a program committee to plan more meetings of this sort.

The mothers discuss such subjects as food, children's books, and emotional difficulties of children. At one meeting they exchanged food recipes, and talked about using parents' recipes for dishes that they, the foster parents, were unfamiliar with. Some of these were foods liked by families that still follow the cooking habits of their old-country forebears.

At the meeting on books, the foster parents discussed the selection of titles suitable for different age groups and how to encourage good reading habits.

A psychiatrist led a discussion on the emotional difficulties of sick children who are separated from their families. The foster mothers brought out with much interest various ways to handle effectively the beginning of a child's stay in a foster home, their experiences in giving the child the affectionate care he needs all the time he is in the home, and how to work out relations with the parents.

Appreciation of work well done comes to the foster mothers in various ways. Perhaps the most rewarding of all is the comment of a physician as he examines a child in the foster home or clinic. At this time he notes the progress and speaks of it. On these occasions the foster mother, physician, nurse, and case worker can rejoice together over the child's gain and can confer on further steps. Helping a child to return to health has other satisfactions. Foster-home "alumni" groups are growing in number and in enthusiasm. The unofficial follow-up that happens spontaneously when former patients visit, write, or telephone foster mothers is satisfying to the mothers and usually to the former patients also.

Social case-work service

The function of the agency, as we have said, is to provide care in foster homes to children with medical problems and to provide them and their families with social case-work service adapted to a medical-care setting. These services include: "Intake" activities, that is, interviewing applicants for the agency's service and studying the situation to ascertain the suitability of the service for the child; finding desirable foster homes; and counseling with parents and with foster parents. The case worker coordinates the services in the foster home with the services of the medical director, of hospitals, of clinics, and of private physicians whose patients are in the home, and with the services of the other professional workers who may serve the children.

Because children are referred to the agency on the basis of medical considerations, the case worker's first concern is the medical data available from the hospital or other agency or person referring the child. When this, with the summary of the social study made, is in hand, the first interview with the parents takes place and planning begins. The case worker makes a visit to the child's home. If the boy or girl is away in a hospital or an institution, the worker visits him there to establish the link between them.

She explains the service to the child's family—what the foster homes are and what the foster mothers do, and what medical supervision is provided. She tells the family about activities in the foster home. As the child's parents learn to know the case worker, they gradually reveal to her what the most acute problems are. That helps the worker to decide what the focus of her treatment may be.

The benefits these children and parents may derive from case-work service grow chiefly out of the relations between the worker, the parents, and the child in their united efforts to restore the child to health. Many others share in these efforts. The case worker makes available to parents and child her ability to help them with their emotional problems—or any problems that are related to the child's illness. If they can learn to make use of the worker's knowledge of why people—children or adults—act as they do and of her skill in helping people solve their problems themselves, they can sometimes find

(*Continued on page 124*)

He's going home! His foster mother of 6 months and her family of boys are glad he is well.

HOW MANY BABIES?

DOROTHY D. TUTHILL, Ph. D.

THE LARGEST NUMBER of births in the entire history of the United States was chalked up in 1947. Although the number was high in 1948, and the estimates show that it will be high in 1949, 1947 is still the leader. With so many births occurring annually, it takes time to collate all the necessary information about the people who have babies, and it was not until the middle of 1949 that the National Office of Vital Statistics released detailed data on the record-breaking number of births occurring in 1947.

Record number of babies born

The number of births registered during 1947 was 3,699,940. Actually, the number of births during the year was greater, because the births of an unfortunate group of babies, estimated at about 4½ percent of the total, did not have birth certificates filed for them. The number of babies that do not have certificates is thought to be decreasing in proportion annually because now no reputable doctor will assist at a delivery, and no hospital of standing will accept a maternity patient, without making provisions for the baby to have the advantage of one of the most personal and most important of all legal documents, a filed certificate of birth. It is probable that slightly more than 175,000 births were not registered; therefore the estimated total of infants born during the year is 3,876,000.

About 400,000 more births were registered in 1947 than in 1946, and the figure for the 2 years combined is almost 7,000,000.

A birth rate is a handy tool for making comparisons in the number of births from year to year when we wish to consider the size of the population at the same time.

The graph on this page, published March 30, 1949, by the National Office of Vital Statistics, shows crude birth rates calculated for each year since the individual States started sending facts about births to the Federal Government. (Special Reports, vol. 31, No. 2.)

One glance at the graph and we can understand why the population experts are watching the Government's annual reports on births as carefully and as anxiously as a stockbroker studies the ticker tape.

A fairly consistent decrease in the birth rate is observable from 1915 to 1933, with the exception of the sporadic peak following World War I. The low point in 1933 is unquestionably related to the economic depression. Because of the poor employment picture during the thirties, marriages and children were postponed, and this caused a drop in the rate. The birth rate was so low during the depression years that if it had continued at that level for any extended period, the population of the United States would have decreased, in spite of the declining death rate.

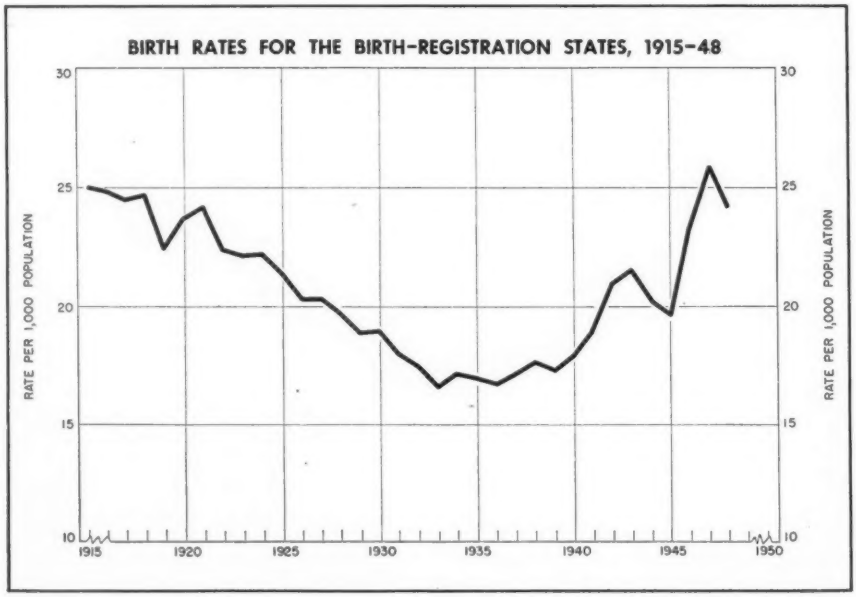
Births rose in early war years

The high economic level during the years just before the last war, together with Selective Service legislation and the anticipation of a conflict involving our country, accelerated the marriage rate. And within a year the birth rate began to rise fairly sharply. By 1943 the birth rate had climbed to a level comparable to that in 1925.

The next change in the trend was a decline, extending over a 2-year period coinciding with the shifting of husbands and prospective husbands from the general population into the Armed Forces. In midyear 1945, a month after VE-day, it is estimated that about 7½ million members of the population were out of the country.

However, demobilization began to occur fairly rapidly after VJ-day, and many returning servicemen married. The highest marriage rate ever recorded in the United States, a rate of approximately 16 marriages per 1,000 of the population, was tallied in 1946. During the year 32 people out of every 1,000 in the population said, "I do."

The high marriage rate, relatively good wages, and our national demand for consumer goods that we had voluntarily denied ourselves during the



war years all combined to make conditions auspicious for a new increase in the birth rate. The graph shows the steep rise for 1946. Some experts thought that the rate would surely decline in 1947, but instead it rose still higher.

How old are the women who are having such a relative abundance of babies? In 1947 women between 20 and 24 years of age had more babies than women in other age groups. And, women between 25 and 29 came next. These two groups, including women between 20 and 29, were the mothers of more than 60 percent of all the babies born in 1947.

The number of women in the different childbearing years is not the same, and so a rate is used to express the proportion of women in any age group having babies. This rate is called the "birth rate by age of mother."

How to calculate a birth rate

It is figured by dividing the number of live births to women in a specific age group by the number of women in that age group. Sometimes this rate is criticized because not all the women in the age group are married, and because a sizable number of those who were married are divorced each year. Of course some divorcees remarry within a short time and some do not. Then there are other women in the age group who are married, but either they or their husbands are sterile and consequently cannot add to the number of births.

The next graph, published October 8, 1948, by the National Office of Vital Statistics, shows birth rates, by age of mother, from 1920 to 1947. (Special Reports, vol. 33, No. 1.)

The graph shows clearly what was mentioned earlier, that births to women between 20 and 29 years of age are consistently higher than those for any of the other age groups; this finding is not unusual.

The findings that the graph points up are that from 1920 to 1947 the greatest variation in the rate was within these ages. This is the group that has apparently reacted most strongly to changes in the economic pattern and to the displacement of men by induction into the armed services.

A second fact that caused fresh speculation among population experts was that birth rates were higher in 1947 than in 1940 for *all* age groups of women. In other words, a larger proportion of women 35 years of age or over had babies in 1947 than in the years just preceding the war. The impetus to start, or to add to, an already established family has definitely not been confined to the younger women. One may also speculate about the fact that birth rates for women less than 30 years old were all higher in 1947 than they were in the period following World War I.

One way to approach the question of family size is to survey the birth data by order of birth. How many of the new babies in 1947 were first babies, and how many arrived to discover that they had an older brother or sister? There is no question that the record of almost 2⅓ million marriages in 1946 contributed to a remarkably high rate of first babies in 1947. In fact, the number of first babies to every 1,000 white women between the ages of 15 and 44 years in 1947 was approximately 22 percent higher than the corresponding rate in 1946. There were increases also in second and third births, but these increases amounted to one-half or less the increase for first births. The proportion of fourth and higher-order births changed only slightly.

In round numbers, for 1947 alone, 1½ million families had their first child; a second child was added to nearly a million additional families; and another half-million families had their third child.

Families postponed by war

After sifting through these and additional facts, P. K. Whelpton, of a research organization at Miami University, Oxford, Ohio, finds that the record-breaking number of first births in recent years is largely the result of starting families that were postponed by the war, and of the decisions by newly married couples, because of prosperous times, to have a first baby within a year or two. He believes that the boom in second and third babies is related to similar decisions, but not necessarily to a lasting increase in average family size.

When wages are good and the chances of unemployment appear slight, the financial responsibilities associated with having a baby, such as the hospital and

doctor bills and a layette and other equipment, plus a little every month toward a college fund, do not appear unattainable. Furthermore, the recent war years brought an insistent demand for a large domestic labor force, and this led to an extension of nursery-school facilities so that more mothers of young children could work. These facilities are in part still available for women who are convinced that they can successfully combine child rearing and working.

With the popularization of new material on the psychological importance of family structure to the growing personality of the child, the fact has taken root that youngsters who are not many years apart can enjoy each other more and contribute more to their mutual socialization. When times are hard, parents may not contemplate having a second or a third child until the family finances seem more secure. As a result, children are farther spaced and many have less in common. When family income appears fairly stable and adequate, having two or three youngsters not more than a year or two apart is less hazardous an undertaking.

There is no question that if the fertility pattern for 1947 were to continue over a period of a decade or more, there would be a growing trend toward larger families than we see now. With the fresh and continuing data provided each year by the National Office of Vital Statistics, we can periodically speculate on the far-reaching implications of such questions as changes in family size and in the birth rate ups and downs.

AMENDED FAIR LABOR STANDARDS ACT IMPROVES PROTECTION OF CHILD WORKERS

WM. R. McCOMB

Administrator, Wage and Hour and Public Contracts Divisions, U. S. Department of Labor

JANUARY 25, 1950, marked a major advance in Federal protection of boys and girls employed in interstate industry. For, on that day, amendments to the child-labor provisions of the Fair Labor Standards Act of 1938 became effective, amendments that will do much to eliminate the evils of child labor.

The amendments have broadened the act in two ways: (1) It now protects children in some interstate industries that were not covered by the original act. (2) It now gives children in agriculture its full protection during school hours if the crop is for interstate commerce.

The protection of the act is now extended to a great many more children and young people than were previously reached. In industries other than agriculture, an estimated 75,000 more young workers will be protected during the school year and 150,000 during the summer. And uncounted thousands of children will have an opportunity to go to school instead of working in the fields while school is in session.

Originally the child-labor provisions applied only to children employed in or about an establishment producing goods for shipment—or delivery for shipment—in interstate commerce, if the goods were removed from the establishment within 30 days of the employment of the under-age children. This meant that most of the children working in the transportation, communications, public-utilities, and contract construction industries were outside the child-labor protection of the act, as well as many working in trade. For many establishments in these industries did not produce goods for interstate shipment. Now the child-labor provisions have been extended to prohibit directly the employment of "oppressive child labor" (as defined in the act) in interstate commerce or in the production of goods for interstate commerce. As a result, minors working on boats, or for trucking concerns or railroads, or as telegraph messengers, and in some other lines of work will also be protected.

Also, for the first time, children in agricultural areas have the same protection from employment that would interfere with their opportunity for schooling as do city children. The child-labor provisions of the act, although they applied to some agricultural employment, did not apply to such work except at the times when children are required by State law to attend school. Although this might seem to protect children from agricultural employment that interferes with their schooling, it did not work out that way in all the States.

These provisions now apply in all States to all children under 16 years of age employed on farms producing crops for interstate commerce (other than their parents' farms) except when school is not in session.

The only other exemptions from the child-labor provisions of the amended act, outside of the exemption in case of employment by the child's parent, are for children employed as actors and performers in motion pictures, theatrical productions, and radio and television productions; and for employees engaged in delivery of newspapers to the consumer. Exemption of employment by a child's parent applies only to occupations *other than* manufacturing, mining, or hazardous occupations.

No change has been made in the minimum-age standards set by the act. The minimum age for employment in occupations covered by the act is still 16 for children working at most jobs; 18 for those working in particularly haz-

(Continued on page 127)

CHILDREN BENEFIT FROM OLD-AGE AND SURVIVORS INSURANCE

NAOMI RICHES, *Division of Program Analysis, Bureau of Old-Age and Survivors Insurance, Social Security Administration, Baltimore*

MORE than six hundred thousand children are now receiving monthly benefit payments from old-age and survivors insurance under the Federal Social Security program.

Many of us may be accustomed to thinking of the old-age and survivors insurance program mainly as providing some income for old people who are no longer earning wages. As a matter of fact, this was true of the program as originally defined in 1935 when the Social Security Act was passed. Benefits for the worker's family after he retires and after his death were added by amendments in 1939.

When the breadwinner of a family dies, the children, even as other dependents, might be left in want but for the income provided by some kind of insurance; the survivors insurance provisions of the Social Security Act help protect children against such want. And though of course there are not a very great number of children under 18 whose fathers are past 65, those children also often need the protection given them by the children's benefits included in their fathers' old-age insurance.

Present act provides for children

Thus Social Security insurance, which began but a few years ago as a system to provide a small retirement income for workers as individuals only, today includes two features of direct importance to children—the additional benefits for children of retired workers and, much more important even, the benefits for the children of workers who die earlier in life.

Children's benefits from old-age and survivors insurance are one of the three ways in which the Social Security program helps families protect their own children. These three ways are through insurance, through assistance, and through community services. The insurance is called old-age and survivors insurance; through it a worker earns rights to insurance benefits for his family (in addition to his own benefits) when he retires after reaching the age of 65, and insurance benefits for his family when he dies. The assistance plan is called aid to dependent children; through it, payments are made direct to families for children in need. The community services are the health services and social services for children and the services for crippled children, which are provided with the help of Social Security grants. Under the Social Security Act, the insurance provisions are handled entirely as a Federal Government program—it is the only program under our Social Security system that is actually operated by the Federal Government. Aid to dependent children and the various services for children (as well as the rest of the programs under Social Security) are provided by the States and localities with the help of Federal grants-in-aid.

Of the three ways in which the Social Security Act helps safeguard children, children's benefits from insurance are perhaps the least well known. Hence, some explanation of old-age and survivors insurance as it concerns children may be of interest to readers of *The Child.*

Insurance benefit payments for children are made on the basis of the insurance earned by their parent (usually their father, though a mother may be an insured wage earner). Consequently, the first requirement in order that a child may receive benefit payments is that he be the child (natural or adopted) of a worker insured under the Social Security Act.

Benefits are payable to a child of an insured worker who has reached the age of 65 and has retired, and to a child of an insured worker who has died. In either case the benefits are paid for the child each month until he reaches 18 years of age, except that no benefits are payable to a child who has married, and no benefit can be paid for any month in which the child is employed in industry or commerce and receives wages of as much as $15. And if the child's benefit is based on his parent's retirement benefit, both the parent's monthly benefit payment and the child's monthly payment are held back for any month in

More than six hundred thousand children in the United States are now receiving monthly benefit payments from old-age and survivors insurance under the Social Security program.

which the parent receives $15 or more as compensation for employment in industry or commerce.

To go a bit more into detail (but still generalizing a great deal), let's start with the wage earner whose insurance provides for his child's benefits.

Insurance under Social Security is much the same as all "retirement insurance." It is insurance purchased by the payment of premiums over a period of time. The big difference in Social Security insurance is that the premiums are paid in the form of a "withholding tax." Beginning the first of 1937 a Social Security tax has been paid on the wages of jobs that the Social Security Act placed "under Social Security." That Social Security tax is, in effect, the payment of premiums on an insurance policy, so that workers in jobs under Social Security become "insured." The act goes into some detail concerning the kinds of jobs that are covered and those that are not covered, but we can describe them in broad terms. Jobs under Social Security comprise practically all jobs for wages (that is, when the worker is not self-employed) in industry or commerce—work in offices, stores, factories, construction, and so on. Jobs that are not under Social Security comprise, still speaking broadly, jobs in agriculture, jobs in domestic service, government jobs, and the jobs of those who are self-employed, who don't work for somebody else, like doctors, lawyers, owner-operators of small grocery stores, and so on.

So a worker in a job under Social Security is in effect automatically paying premiums on insurance—for himself and his family. But for a worker to be entitled to retirement benefits, or for his family to be entitled to survivors benefits if he should die, he must have worked in jobs under Social Security for a certain minimum length of time. The amount of a worker's benefits, and of his family's benefits, is determined by the total amount of wages he has received from all his employment in jobs under Social Security.

The minimum period of covered employment required for a worker who reaches the age of 65 is, roughly, half the time from January 1, 1937 (when Social Security coverage began), to the time he reaches age 65. The employment doesn't have to be continuous, and all employment in covered jobs is counted. A worker (at any age) who has completed a total of 10 years of covered employment is insured for life, regardless of future employment—but of course the size of his benefits at retirement, or of his family's benefits if he dies, will be based on the amount of his wages from all his covered employment.

The minimum period of covered employment required in the case of a worker who dies is similar, that is, half the time from the beginning of 1937 to the time he dies. Or he could be permanently insured with 10 years of covered employment. Or he is insured at death if during 3 years preceding his death he was in covered employment for approximately half the time.

It may be noted that although the benefits for survivors were not added until 1939, a worker's employment is figured from the first of 1937 for survivors insurance just as for old-age insurance, since that is when the workers came under Social Security.

The 10-year provision for a permanently insured status is not especially significant at present, inasmuch as Social Security has been in effect only some 12 years. But when the insurance program has been in force a few years longer this 10-year provision will have increasing importance for many workers, since it will probably become a less difficult condition to meet than the provision of half the time since the act became effective.

When an insured wage earner reaches the age of 65, and is no longer employed in a job *under Social Security* (to be a little more exact, if he no longer works for wages of more than $14.99 a month in employment that is under Social Security, though he could work for compensation of any amount in a job that is *not* under Social Security) he is entitled to a monthly benefit payment. That monthly payment to the retired wage earner is spoken of as a "primary insurance benefit." Its size depends on the amount of wages and the length of employment in jobs under Social Security. The law says that in any event it shall not be less than $10 a month. At present the most that a retired worker's benefit could be is a little less than $50.

In the case of a worker who dies, a "primary insurance benefit" is computed in the same way as for a worker who retires, and the amount of this primary insurance benefit of a deceased worker determines the amount of the survivors benefits payable to his family, just as the additional benefits for the family of a retired worker are based on the amount of the worker's own primary insurance benefit.

A child's insurance benefit is based on the primary insurance benefit of his insured parent, whether the parent has retired or has died. The amount of a child's monthly benefit ordinarily is one-half the amount of his parent's primary benefit. Each of a worker's unmarried children under 18 years of age is entitled to a child's benefit. A widow of an insured worker who has a child or children of the worker in her care is entitled to a "widow's current benefit" amounting to three-fourths the amount of the worker's primary benefit. The widow's current benefit is payable regardless of her own age. (The wife of a retired worker is entitled to a wife's benefit amounting to one-half the worker's primary benefit, when she herself reaches the age of 65; the widow of an insured worker is entitled to a widow's benefit amounting to three-fourths of the worker's primary benefit when she reaches 65, regardless of whether she has children in her care.)

As we have noted, a child's benefit is paid each month until the child reaches 18 or marries, except that no benefit can be paid for any month in which the child is employed in industry or commerce for wages of as much as $15. A monthly check is paid to a widowed mother as long as she has a child beneficiary in her care, provided she has not remarried and is not earning wages of $15 or more a month in employment covered by Social Security. If her benefits are suspended by reason of such employment, her children nevertheless continue to receive their monthly benefits. Likewise, if she remarries, her own benefit payments are stopped, but the children continue to receive theirs.

Maximum set by law

There are limitations on the benefits that can be paid one family, that is, that can be based on one worker's wage record. The law says the survivors benefits for a family must be at least $10. It limits the maximum amount in three ways. It states that the total benefits

payable to one family cannot exceed whichever is *smallest* of three amounts, either $85, or twice the amount of the worker's primary benefit, or four-fifths of the average monthly wage on which his primary benefit was based. If applying any of these "maximums" would reduce the total of the family's benefits to less than $20, the total amount is kept at $20.

As of June 1949, the average payment made to a child was about $13 a month and the average payment made to a widowed mother was about $21 a month. In that month alone, some 8 million dollars were paid to about 615,000 children and some 3 million dollars to the widowed mothers. From January 1940, when family benefits were first included in the insurance program, to June 1949 more than 447 million dollars were paid to survivor children and nearly 217 million dollars to their widowed mothers. During the same time more than 18 million dollars were paid to children of retired workers. Since the program began, more than 900,000 children have been awarded monthly benefits.

These benefit payments, like the rest of the insurance benefits under Social Security, came from the trust fund into which wage earners in covered employment, and the employers of those wage earners, contribute equally through the Social Security tax.

Survivors insurance under Social Security, like other forms of insurance, is a method of spreading the risk. The death rates for the ages at which workers would be expected to have young children are not so high, and by spreading the economic risk of early death among all workers, each worker can have protection for his own family at relatively low cost.

Parent provides for child's support

Insurance payments to the family are made with no means test, no case-work investigation, and are subject only to verification of the age of the children and the relationship of the dependents to the deceased worker. A child can feel that provision has been made by his parent for continuing some financial support even after the parent's death.

Not all of the children's benefits are paid on wage records of fathers. A widowed mother may be the insured breadwinner who dies and on whose wage record benefits are paid to her children.

For total orphans whose parents were both insured workers, monthly benefits are paid on either the father's or the mother's wage record, whichever gives the higher benefit. In the case of children nearing the age of 18 the checks are usually made out direct to them. For younger children the payment is customarily made in behalf of the child to a person with whom the child is living.

Orphans are more numerous than many people suppose. The latest figures now available are from the 1940 Census. They show that nearly a tenth of the more than 40 million children under 18 have lost one or both parents. Of these, more than 2 million have lost their fathers and more than a million have lost their mothers. Nearly 300,000 have lost both parents. The 1950 Census will undoubtedly show an increase in the actual number of orphans because of the increase in the whole population. The proportion of orphans to the total number of children will probably be about the same. War casualties fortunately were not so large as to affect the situation in this country as they did in European countries. The 1940 Census gives some interesting data by age for these orphans. Of all children aged 15 to 17, nearly 18 percent have lost one or both parents. About 3 percent of all children under 5 have lost one or both parents. Students of population problems have observed that complete orphanhood is much more frequent than would be expected from the separately computed chances of losing father and of losing mother. There are more than 10 times the number of total orphans that might be expected on the assumption that the loss of one parent has no effect on the probability of also losing the other.

Congress made provision in the Social Security Act as amended in 1939 for continuing study and for "recommendations as to the most effective methods of providing economic security through social insurance." Accordingly, the Social Security Administration has recommended that social insurance protection be extended to all those gainfully employed, and that the amount of the monthly insurance benefit payments under the act be increased.

For a baby and his widowed mother, survivors insurance under the Social Security Act will provide monthly insurance benefits that will continue for both until the child is 18 years old.

FOSTER HOMES

(*Continued from page 117*)

their way out of the situations that have contributed to the necessity for foster care.

Case-work service, like other professional services that help people understand their difficulties, sometimes seems clearest when its benefits to a specific person are told, along with the way the benefits are brought about. We might look, therefore, at service given to one child in order to see what the agency's case workers try to do for children. Our story is about a child who has asthma and uses it to get her way about things, and in doing so has a serious illness and stays younger than her actual years and behind her capacity for development.

A case worker and one little girl

A children's hospital asked the agency to place one of its recently discharged patients, 6-year-old Maria Q. She had come to the hospital acutely ill as a result of asthma, which she had been having for 3 years. She was greatly improved at the time of her discharge from the hospital. She stayed briefly in an institution for convalescents before she went back to her family and she was entirely free from symptoms as long as she was away from home.

Now at home, she was having attacks again. At the hospital and at the institution she had had a good, healthy appetite. At home she was eating, between meals, all sorts of food that was not good for her. Someone had to dress and undress her. Her entire family—parents, grandmother, and the three older children—gave in to her; if they did not, she would have an attack of asthma. The latest development was her refusal to go to school. The doctor requested foster care for her because he believed the child's life would be endangered if she continued to have severe attacks; she was likely to continue to have them unless her home situation was changed.

What was the situation that was leading to Maria's physical illness? When the agency's case worker first talked with the child's mother about the possibility of Maria's going to a foster home until health habits could be established to prevent asthmatic attacks, Mrs. Q. asked axiously, "When my little girl was so well at the institution, why does she have asthma as soon as she comes home?" The case worker helped her find the answer to that question through many talks with the parents and with Maria herself during various associations; by close observation of the relations between the different members of the family; and through the various case-work processes by which the worker helps persons to learn to see their problems more clearly and to face the need of solving them.

Briefly, here is the home situation that faced Maria when she started to develop asthmatic attacks as a defense and a weapon. She had had this illness first when she was 3. Shortly afterward her brother Michael, the fifth child, was born. Maria, until then called "Baby," became very jealous of the attention the new baby received. She tried to maintain her old status of having her parents' whole time and affection by having attacks of asthma—and found that it worked.

She ignored the baby completely, and his hatred of her became obvious. It is easy to see that this tension would in time have serious results. It did. Maria's attacks came more frequently and with greater intensity. Some member of the family had to get up to give her medication almost every night. Her physical condition became acute, and a doctor sent her to the children's hospital that was now asking foster care for her.

It is well known that jealousy of a newborn brother or sister is not unusual when mothers and fathers do not know how to prepare the older child for the new arrival. It can, of course, be overcome by wise handling of the situation when parents learn to show their affection equally and to bring disgruntled older children into the circle of their own enjoyment of the youngest one and into the fun it can be for a family to have a new baby. Unfortunately, Maria's parents—especially the mother—were too deeply disturbed themseves by their own problems to be able to help little Maria and Michael. What was their mother's chief problem? She was not, it was clear to the social worker, really acting as her children's mother.

Mrs. Angela Q., the mother, had come to the United States from Italy when she was 15 to marry her cousin, a fisherman. From the first she lived with her mother-in-law (her own mother's sister), who had been in this country a long time. Angela had not become grown up enough before marriage to sever her tie with her own mother and had immediately become a dutiful, pliant daughter to her mother-in-law in an adolescent way. This tie was still binding her, the mother of five children, while Maria was so acutely ill. The tie was a damaging one. The mother constantly had to give in to her mother-in-law about matters small and large—even about bringing up the children. The grandmother, without consciously realizing it, effectively turned the children's love away from their mother to her. She did this partly by insisting that the mother punish the children constantly for things they did and then solacing them, herself. When Maria began to use asthmatic attacks to gain attention—the grandmother encouraged this by her excessive concern and frequent expressions of sympathy.

All the members of the family were subject to respiratory infections, their colds and similar ailments appearing in time of emotional stress. The elder Mrs. Q. used her own symptoms as one way to control her daughter-in-law. She would keep the younger woman at home to attend to her invalid wants instead of urging her to go out with her husband as she had planned. So Maria's father and mother, who were exceedingly fond of one another and had similar recreational interests, could scarcely ever spend their leisure time together.

When it was first suggested to Mrs. Q. that Maria stay in a foster home for a time while she was being helped to overcome her difficulty with asthma, the mother was bewildered. She could not make up her mind about it. She was an extraordinarily hard-working woman, a good housekeeper, and a person of high ideals about the responsibility of parenthood. It was bitter for her to acknowledge the fact that she had been unsuccessful so far with Maria. She finally agreed to the placement because the foster mother who was proposed for Maria was a nurse; the mother had finally realized that the little girl was in danger if her attacks of asthma were not stopped, or at least lessened. Mrs. Q.

was willing to try care in a foster home because she had seen that Maria was well when she was away from home. So Maria went away from home again.

Now the foster mother and the case worker worked with Maria toward helping her to manage her own life in accordance with her age. The child had asthmatic attacks periodically for the first 7 months and also had bad dreams that awakened her. The foster mother, observing her closely, found that a *placebo*, that is, a preparation given merely to satisfy a patient, was as effective as medication for the attacks when Maria awoke at night.

The foster mother heard the little girl tell the other children, "I'm not punished at home because I'll have asthma." This habit of Maria's the foster mother began to change, gradually, by showing appreciation of positive accomplishments rather than showing undue sympathy for illness and allowing the avoidance of illness to be the basis for decisions.

Maria loved her foster mother and wanted to do things to please her, such as dressing and feeding herself. But sometimes she would slip back into her baby ways. She saw a crib being set up for another child and asked to sleep in it. She was allowed to do so but, in time, left it of her own accord, easily, because she wanted to seem more grown up. She developed a healthy appetite for natural, nourishing foods, a real advance. She became less remote and sullen, even livelier in her manner. She found new, interesting things to do.

The case worker and the foster mother worked together to help Maria. The episode of the crib had followed a conversation the child had had with the case worker about Michael on the way back to the foster home from a visit to the clinic. Maria complained that her "baby brother Michael" had once pushed her out of her crib. The case worker said she could understand that this would make Maria angry. Maria replied that she wished a baby girl would come into the family to push him out of his crib. It was after this conversation that she had asked to sleep in a crib and was allowed to do so until she was ready to leave it for a bed. While she was sleeping in the crib she began calling Michael "my brother Michael" instead of "my baby brother Michael," thus recognizing him as a person of 4 years of age. As time went on, the breach between them slowly healed. When they saw one another at Maria's visits to the clinic, they would start to play, scuffling together affectionately.

On another occasion the case worker remarked to Maria how much more grown up she was becoming, adding with a smile that Maria could show her foster mother how grown up she was by not waking her in the night. The foster mother, learning about this talk, made the most of it.

Meanwhile, the case worker was working with Maria's parents. The mother kept numerous appointments for interviews. They talked about Maria's progress, the mother taking up matters that were not clear to her. The case worker explained Maria's improvement, as the child responded to her foster mother's approval of gains rather than approval of illness. Sometimes the father came to the interviews also and he was much interested in this method of preventing Maria from having attacks of asthma, seeming to understand it well. The parents asked, practically, what they could do. After a while they made a plan based on this idea: "When we meet Maria on her visits to town for clinic appointments, we'll speak of her pretty hair ribbons, or her pink cheeks, or how tall she is getting, instead of asking, 'Have you been wheezing'? And we'll think about Michael too now; we'll love him and give him some of the attention he missed as a baby when we were so worried about Maria's attacks."

But the mother's struggle to become an adult emotionally and to take over the management of her children from her mother-in-law was not easy. The first time Mrs. Q. expressed her hatred for her husband's mother, early in the interview, she became so disturbed that discussion of this relationship had to be kept in abeyance for a while. Gradually, the mother learned to express her feelings and to make it clear that she really wanted help. She asked specifically about how to handle the three older children and began to develop happier relations with them. As she felt herself becoming a real mother rather than an adolescent who was dependent on her mother-in-law, she was able to talk about this long-time situation with greater ease and as a result lived more comfortably with the woman who had dominated her for so many years.

Now that Maria has been more than a year in the foster home, she shows progress in various ways. While waiting in the clinic to see the doctor she does not sit on her mother's lap long but soon jumps off to play. She loves school now and is doing well. Soon she may be able to make visits home. Eventually, when the family situation has changed more, it is hoped she will be able to go home to live and will stay well.

The efforts of the Children's Mission to Children to help Maria overcome a recurring illness illustrates one use of medical foster care. The experience of this little girl in living in a foster home under medical supervision and under treatment by a case worker while a change in the pattern of her family's living was being brought about shows what a children's agency specializing in medical foster care may accomplish. But the accomplishment depends on many factors. Among them are careful selection of situations in which improvement is possible and the ability of the parents to use case-work counseling to effect the change necessary.

What it takes

If we of the Children's Mission to Children were asked what was most important in *medical* foster-home care for children, we could not name one part of the care only. The principles of good foster-home care apply to this specialized work. The requisites of a good program of medical foster care are: (1) The team work of physician, nurse, foster mother, case worker, occupational therapist, and other specialists as their services are needed; (2) adequate compensation to foster mothers; (3) a planned program of activity in the group homes, especially in homes giving bed care, because children confined to bed have such limited contacts; and (4) case-work service that concentrates on family problems affecting the health of a child and on counsel to child and foster mother that will make the placement of children with medical problems bring the results hoped for.

ONE APPRAISAL OF THE EMIC PROGRAM

WE ARE QUOTING here, from the December 1949 issue of the *American Journal of Public Health*, a statement on the Emergency Maternity and Infant Care Program, which was administered by the Children's Bureau for 75 months—from April 1943 through June 1949.

"The termination of the EMIC program on June 30, 1949, closed a gratifying and encouraging chapter in the history of medical care in the United States.

"As our readers are aware, EMIC was a wartime program operated by the State health departments to give medical, nursing, and hospital maternity and infant care to wives and babies of enlisted men in the four lowest pay grades, about three-fourths of the armed forces. Funds were supplied by Congress through the Children's Bureau within the framework of the Social Security Act. The fact may not be clearly realized that, at its height, this program covered one out of seven of all births taking place in the United States. Its purpose was to give a serviceman assurance that his pregnant wife and his coming child would have good medical care, and that the cost would be paid for from general tax funds. Men returning from World War II did not face unpaid maternity bills as did those of World War I.

"It is probable that the most important long-range influence of the program was its emphasis on quality of care, which not only affected the mothers and infants who received direct services, but raised the local level of maternal and child care in entire areas, where the level had before been low.

"Minimum standards were established for hospital, maternity, and newborn services for the first time in many parts of the country.

"The EMIC medical advisory committees appointed by State and local health departments were a potent force in maintaining a high quality of medical care under the program by recommending standards of prenatal care, by establishing lists of consultants competent in various specialties, and by urging the general practitioners to call the consultants who were made available under the program.

"Many mothers whose husbands were not in service learned from EMIC patients what to expect in the way of good medical care throughout pregnancy, at delivery, and after the baby's birth. They learned for the first time what good health supervision and medical care for an infant really is.

"More widespread appreciation of the value of hospital care as a result of the EMIC program was partly responsible for the fact that in 1947 the proportion of births occurring in hospitals reached a new high of 84.8 percent, as compared with 72.1 percent in 1943, an increase of almost one-fifth. This occurred in spite of the great postwar rise in the birth rate and the shortage of new hospital facilities.

"All physicians were paid for their services, and though in some parts of the country the rates of payment were less than is customary in private practice, in other areas the rates were better than the prewar average. Hospitals were paid on a cost basis, and they—like the doctors—had no 'bad bills.'

"Since the principle was established under EMIC that payment by the State agency must constitute full payment to the hospitals and physicians, it was essential that rates of payment to physicians and hospitals be made equitable.

"The per diem cost formula for payment to hospitals was accepted, in general, to a surprising degree. Incidentally, the fact that there was no additional payment for surgery (such as Caesarean section) included in the program avoided any possible incentive to unnecessary surgical interference.

Every State had EMIC program

"One of the most amazing features of the EMIC was the facility with which every State health department established the machinery for administering this medical-care program, involving practically all physicians and hospitals in the State. Many of the

patients were moving from State to State; and it was not found difficult to arrange for continuing care, since the programs, almost identical in scope, were in operation in all States.

"Although there were many complaints at one time about too much Federal insistence on reasonable uniformity of the State programs, most of the States welcomed the fact that they did not have to negotiate locally without full support of the Children's Bureau, with respect to the basic principles involved. The Children's Bureau, with the best medical advice it could secure, had, of course, to bear the ultimate responsibility of seeing that care was made available under conditions which were as equitable as possible to all concerned.

"The average cost during 1943–48 of EMIC maternity cases completed was $92.49 for medical and hospital care; and for cases of infant care completed it was $63.89. The $127,000,000 paid to State health departments bought for almost 1¼ million mothers and their infants the health supervision and medical care they needed. State health departments learned that the cost of administration in such a medical-care program was very low compared to the costs for service. Although accurate totals for State and local expenditures for administration have not been compiled, the States usually estimated them as considerably less than 5 percent.

"The Children's Bureau administered its responsibilities for the program with its small prewar staff, and it had no new funds except for three auditors rather late in the program. There is an immense amount of valuable factual information available to the State health departments which have the time and the money to finance the analysis of their medical and administrative records under the EMIC program.

"A few such studies have already been initiated. Public-health workers will find a mine of information about the administration of EMIC in the report of a study made by the School of Public Health, University of Michigan, while the program was in full operation. Dr. Nathan Sinai directed the study and reported his findings in *EMIC—A Study of Administrative Experience*. One of his conclusions summarizes well the administrative lesson to be learned from this wartime medical-care program.

" 'EMIC serves as a striking demonstration of joint effort and of administrative resiliency. It would be hard to find another wartime program that grew to such comparatively huge proportions and still remained within the framework of an existing national, State, and local peacetime administration. The accomplishments in meeting the problems, disregarding the antagonisms, conflicts, and fears, are a monument to the combined contributions of medicine, public health, and the hospitals. Maternity and infant care were the goals; maternity and infant care are the achievements.' "

CHILD WORKERS

(*Continued from page 120*)

ardous employment; and, for a few occupations in which the child works outside school hours under specific safeguards, 14 years.

Employers can protect themselves from unwitting violation of the child-labor provisions of the Fair Labor Standards Act by making sure of their employees' ages. This can be done by obtaining State employment or age certificates for minors up to 18 years of age in general employment and also for those claiming to be 18 or 19 years old if they are employed in jobs declared by the Secretary of Labor under the act to be particularly hazardous. Such certificates can be obtained in most States from school officials or State labor-department officials. In four States, South Carolina, Mississippi, Idaho, and Texas, Federal certificates of age are issued through Wage and Hour and Public Contracts Divisions offices.

ED. NOTE.—*The Secretary of Labor administers the child-labor provisions of the Fair Labor Standards Act, and he has delegated to the Administrator of the Wage and Hour and Public Contracts Divisions the duty of making investigations to obtain compliance with these provisions of the act. To the Bureau of Labor Standards the Secretary has delegated the duty of developing child-labor regulations and of working with the States on their employment-certification programs where State certificates are accepted as proof of age under the Fair Labor Standards Act.*

CALENDAR

Feb. 27—Child Study Association of America. Annual conference. New York, N. Y.

Mar. 12—Girl Scouts of the United States of America. Thirty-eighth birthday.

Mar. 12–18—Camp Fire Girls Birthday week. Fourtieth anniversary.

Mar. 14–18—Play School Week. Annual conference of Play Schools Association. Information from the Association, 119 West Fifty-seventh Street, New York 19, N. Y.

Mar. 19–23—International Council for Exceptional Children. Chicago, Ill.

Mar. 26–30—National Society for the Prevention of Blindness. Conference in conjunction with the interim session of the Pan-American Association of Ophthalmology, Miami Beach, Fla.

Mar. 26–30—Council of Guidance and Personnel Associations. Annual convention. Atlantic City, N. J.

Mar. 27–30—National Vocational Guidance Association. Annual meeting. Atlantic City, N. J.

Mar. 29—Alliance for Guidance of Rural Youth. Atlantic City, N. J.

Regional conferences, Child Welfare League of America:

Mar. 9–11—Southern Regional Conference. Shreveport, La.

Mar. 16–18—Central Regional Conference (formerly called the Ohio Valley Regional Conference). Toledo, Ohio.

June 5–7—Midwest Regional Conference. Minneapolis, Minn.

Area conferences, National Child Welfare Division, American Legion

Mar. 3–4, 1950. Area C—Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, Oklahoma, Panama, South Carolina, Tennessee, and Texas. Dallas, Tex.

Mar. 10–11, 1950. Area A—Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont. Hartford, Conn.

Illustrations:
Cover, Federal Security Agency.
Pages 115–117, the Children's Mission to Children, Boston.
Page 120, Arthur Rothstein.
Page 121, Philip Bonn.
Page 123, George Jones.
Page 124, Esther Bubley.

What's Past Is Prologue

Workers for children feel that this country reached another milestone on the road to full child-labor protection, when the recent amendments to the Fair Labor Standards Act went into effect.

As Wm. R. McComb points out in this issue of *The Child*, young workers in a whole new field of interstate industry are now brought within the purview of the child-labor provisions of the Fair Labor Standards Act.

These provisions can now reach boys and girls employed in industries that the original act of 1938 could not reach—industries such as those carrying on transportation and communications, that do engage in interstate commerce, even though they do not produce goods for such commerce.

In addition, the new amendments prohibit employment of children in agriculture during school hours (except on their parents' farms) if the crops are for interstate commerce. This will open the way to more schooling for many migratory children and for other seasonal child workers on farms.

It was not until about the beginning of this century that public opinion began to organize on a broad scale to fight child-labor evils. But once we were well into the 1900's, milestones of child-labor progress were not far apart. In 1904 came the organization of the National Child Labor Committee. In 1906 the first Federal child-labor bill was introduced in Congress. A year later, in 1907, Congress authorized a Nation-wide study of woman and child wage-earners. Then, in 1912, the Federal Children's Bureau was established, and in 1913, the United States Department of Labor.

Passage of the first Federal child-labor law marked the year 1916. But progress was slowed when this law was declared unconstitutional. Then, in 1919, a Federal child-labor tax law was passed, and this met the same fate. In 1924 a Federal child-labor amendment was submitted by Congress to the States. In the meantime, many States improved their child-labor legislation, complementing and supporting Federal child-labor regulation. Thus State protection for child workers advanced more rapidly between 1910 and 1920 than in any prior decade.

In the second quarter of the century efforts to help working children ran into difficulties. The child-labor amendment failed of ratification, and the NRA codes, with their child-labor provisions, were cut short by an unfavorable Supreme Court decision. But before long a Nation-wide pattern of Federal protection for working children, under the Constitution, was set by the child-labor provisions of the Fair Labor Standards Act of 1938.

Now that this act has been amended to provide still more protection to employed boys and girls, we should congratulate all who were concerned in bringing about this forward step—the many public and private agencies that have worked to obtain the new amendments, as well as the Congress itself. Such an advance in child-labor protection is significant, not only because it prevents employment harmful for children, but because it helps to make it possible for our young people to achieve their own educational fulfillment and personal development.

But there is much more to be done. This new Federal action needs for its full implementation the support of State and private agencies and of the general public—employers, workers, parents. It should give impetus to advances in State standards, which cover not only interstate employment, but also intrastate, and which can regulate night work and other working conditions not within the orbit of the Fair Labor Standards Act.

This is a challenge to every citizen—to work for advances in the child-labor laws of his own State.

Katharine F. Lenroot

Chief, Children's Bureau

VOL. 14, No. 8 FEBRUARY 1950

the CHILD

published monthly by the
Division of Reports
CHILDREN'S BUREAU
Managing Editor Sarah L. Doran
Art Editor Philip Bonn

FEDERAL SECURITY AGENCY
Oscar R. Ewing, Administrator

SOCIAL SECURITY ADMINISTRATION
Arthur J. Altmeyer, Commissioner

CHILDREN'S BUREAU
Katharine F. Lenroot, Chief

CONTENTS

Publication of THE CHILD, monthly bulletin, was authorized by the Bureau of the Budget, May 12, 1936, to meet the needs of agencies working with or for children. The Children's Bureau does not necessarily assume responsibility for statements or opinions of contributors not connected with the Bureau. THE CHILD is for sale by the Superintendent of Documents, Government Printing Office, Washington 25, D. C., at $1 a year. Single copies 10 cents each.

U. S. GOVERNMENT PRINTING OFFICE: 1950